



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EL PASO SPECIALTY HOSPITAL
1755 CURIE DR STE A
EL PASO TX 79902

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number: 54

MFDR Tracking Number

M4-03-5076-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "We are in receipt of the benefit payment for the above referenced claim. It is our understanding that benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items. Implants were paid incorrectly. They should be paid at cost + 10%. Invoice is attached. We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided. Further, many state and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct. Based on this information, we request that the reductions be reversed and an additional payment be made. If your company does not release additional benefits, please submit the applicable policy language which justified the reduction as well as the data used to establish the reimbursement rate so that we may determine your company's and the patient's liability in regard to the unpaid balance."

Amount in Dispute: \$25,524.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Table of Disputed Services: "M, invoice not attached?, M"

Response Submitted by: Texas Mutual Insurance Co., 221 W. 6th Street, Ste. 300, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2002	Outpatient Surgery	\$25,524.69	\$0.00
October 7, 2002			

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 3, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 17, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - M – No MAR
 - JX – Fair and reasonable reimbursement for the entire bill is made on the "O/R Service" line item.
 - TM – Services were reimbursed in accordance with the Carrier's fair and reasonable; cost data is unavailable for your facility at the time. Additional reimbursement may be considered up receipt of this information. Will consider additional reimbursement with submission of manufacturer's invoice. Hospital purchase order was submitted with billing
 - O – Denial after reconsideration.
 - T2 – Reduction was made on outpatient bill.
 - YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
 - YM – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report for each date of service in dispute and the anesthesia record for date of service October 7, 2002, the requestor did not submit a copy of the anesthesia record for date of service September 30, 2002, the post-operative care record for both dates of service, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
4. 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional

documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds no documentation of the requestor's reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).

5. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
6. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated for the charges other than those for the implantables.
 - The requestor articulated a methodology for the implantables but failed to support it.
 - In support of the requested reimbursement, the requestor submitted a redacted explanation of benefits (EOB). However, the requestor did not discuss or explain how the sample EOB supports the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOB was for services that are substantially similar to the services in dispute. The carriers' reimbursement methodology is not described on the EOB. Nor did the requestor explain or discuss the sample carriers' methodology or how the payment amount was determined for the sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 26, 2012 Date
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Signature	Medical Fee Dispute Resolution Manager	January 26, 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.